THE PATIENTS GUIDE TO UNDERSTANDING THE CHIROPRACTIC BENEFIT

WHAT DOES MY PLAN COVER?

Before you begin Chiropractic treatment, it is recommended that you fully understand your Chiropractic benefits.

Your benefit will cover chiropractic adjustments to help achieve symptomatic stability. Once you and your chiropractor have your symptoms under control, the practitioner's goal is then to get you as well as possible and keep you there.

Unfortunately, most benefit plans do not cover chiropractic adjustments to help you maintain your health, to keep your condition from returning, or from getting worse and you will be financially responsible.

Whether you have a Medicare or Medicaid plan, OR a Individual or Commercial health plan, it is important to understand the limitations of your plan benefits as some treatments or treatment modalities may not be covered by your plan or may have an out-of-pocket expense.

Centers for Medicare and Medicaid Services (CMS) further define the standards of Chiropractic care, in relation to reimbursement for treatment, by defining Medical Necessity, Active Treatment and Maintenance Therapy.

WHAT IS MEDICAL NECESSITY?

Medical Necessity is a term the insurance industry uses to define what services are covered by insurance and what services are not covered by

insurance. Health insurance companies provide coverage only for health-related services that they define or determine to be medically necessary. Insurance will not pay for healthcare services that they deem to be not medically necessary.

For treatment to be considered medically necessary, the patient must have a significant health problem in the form of a neuromusculoskeletal (nerve, muscle or bone) condition necessitating treatment. The manipulative services rendered must have a direct therapeutic relationship to the patient's condition and provide reasonable expectations of recovery or improvement of function.

What is Active Treatment?

Active Treatment includes relief, correction, and stabilization of a condition. This care requires frequent visits that reduce in frequency as the patient improves. In addition to the chiropractic adjustments, treatment during this phase of care usually requires additional services or modalities. A doctor-prescribed treatment plan is necessary during this care phase and treatment intervals typically do not exceed 2 weeks. This is the only type of care that is considered by the insurance industry to be "medically necessary" and potentially covered by any insurance benefits.

What is Maintenance Therapy?

When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature (improvement of functional loss), the treatment is then considered maintenance therapy.

Maintenance therapy is meant to prevent future relapse and maintain the condition after active care has been completed. This is also known as Wellness or Preventative Care. This care requires periodic check-up visits to prevent future decline and/or maintain the health status that was achieved during active care. Maintenance care visits are usually anywhere from 2 weeks intervals to 3-month intervals, although most patients would ideally benefit from monthly chiropractic check-ups to stay in optimal health and wellness.

The insurance industry considers maintenance/wellness/preventative chiropractic care to be "not-medically necessary" and therefore does not cover these types of visits – much like your car insurance not covering oil changes and tune-ups which are required for proper vehicle maintenance.

A New Condition

Sometimes accidents happen and your condition may return. In the event this happens after you have reached maintenance or wellness care, you and your practitioner may decide to suspend/freeze your current wellness plan and start a new cycle of active care. In this situation, you may be able to utilize any remaining insurance benefits you have at this time. If you have already reached your Chiropractic limit, based on any plan limitations, you will be responsible for the cost of your care.

Contact your Health Insurance carrier to find out your allowable visits or visit limitations.

My Treatment Plan

Your Chiropractic provider will discuss your treatment plan with you at each visit. Initial Active treatment plans range from 6 to 12 visits, where you and your provider are working towards stabilization of your presenting condition. In extreme cases, Active treatment can take longer than 12 visits and your insurance benefit is designed to cover additional treatment needed for you to reach wellness or maintenance care. Once your condition is deemed stable, your provider should discuss a maintenance treatment plan that best keeps your symptoms from returning.

Of course, a healthy diet and prescribed daily activity, such as exercise and stretching, all contribute to the success of your chiropractic care. Your provider will discuss your maintenance treatment plan once it is deemed that you are no longer in Active Treatment.

PATIENT FREQUENTLY ASKED QUESTIONS (FAQ'S)

"MY INSURANCE SAYS THAT I HAVE 20 OR UNLIMITED COVERED VISITS PER YEAR"

Insurance plan chiropractic limits vary by Health Plan. Insurance will only pay for services that it determines to be "Medically Necessary". If 12 visits are used during an active treatment protocol then they should be covered; however, if additional visits are used on an "as-needed" or "once-a-month" basis or in maintenance care, then insurance will not cover those visits.

Maintenance visits are determined by the insurance industry to be not-medically necessary and are therefore not covered services.

"I JUST WANT TO COME IN WHENEVER I FEEL I NEED TO AND PREFER NOT TO BE ON A TREATMENT SCHEDULE."

That is okay! However, you need to understand that chiropractic treatment provided on an "as-needed" basis is determined by the insurance industry to be "not-medically necessary" and is therefore not covered by insurance.

Even if your insurance benefits say you have a certain number of chiropractic visits per year, those visits need to fall under an active treatment program prescribed by the chiropractor to be covered. Patients that are seen on an "as-needed" basis and are not on a specific treatment plan are required to pay for the services out-of-pocket since insurance will determine the care to be maintenance in nature.

POSSIBLE OUT-OF-POCKET EXPENSES

Your policy may exclude the following services from payment when performed by a Doctor of Chiropractic:

- Evaluation and management services to include examinations necessary to prepare treatment plans required to justify medical necessity of covered services such as manipulation
- Radiographs/X-Rays
- Initial Visits and exams
- Physical medicine modalities such as electric stimulation, ultrasound, or mechanical traction
- Specialty services such as Massage, Acupuncture or Exercise Rehab
- Physical medicine procedures such as manual therapy, therapeutic exercise and or therapeutic activities
- Manipulations outside of Active treatment

We recommend that you discuss possible out of pocket expenses and limitations to your coverage, as it relates to Active and Maintenance treatment, with your provider at the onset of your treatment.

If you have additional questions or concerns please consult with your provider and or Health Insurance carrier.